The Lake Forest College IACUC (Institutional Animal Care and Use Committee) requires that students with extended exposure to animals, such as students conducting independent research projects or students serving as research lab assistants. A student need only complete this evaluation once during their time at Lake Forest College, unless they switch to a different animal system, or something changes in their medical record.

**To complete the Student Health Evaluation, please follow all steps below:**

1. Complete this self-report screening form.

2. Schedule and attend a “Physical Appointment” at the Health & Wellness Center.

<https://lakeforest.studenthealthportal.com/>

3. Bring the completed form to your “Physical Appointment” to be reviewed with the medical provider.

4. Health & Wellness medical providers will evaluate and email IACUC with the student name: “medical evaluation is complete,” if the student is cleared to participate.

5. IACUC will simply log these two pieces of information (student name and “medical evaluation is complete.”

*Please note that this form is part of your confidential medical record that will be maintained securely and in compliance with all federal, state and local regulations that protect the privacy of your medical information. Do NOT send this form to the IACUC.*

|  |  |
| --- | --- |
| **Participant Name** (*Last, First*)**:** |  |
| **Department:** |  |
| **Email:** |  |
| **Preferred Phone:** |  |

**A. TETANUS IMMUNIZATION**

**1.** **What is the year of your last tetanus immunization?** *(Recommended every 10 years.)*

|  |
| --- |
|  |

**B. ALLERGIES/ASTHMA/SKIN PROBLEMS**

**1. Are you allergic to any animal(s)?**

|  |  |
| --- | --- |
| Yes | No |
|  |  |

*If yes,* please list the animal(s) and your associated allergy symptoms:

|  |
| --- |
|  |

**2. Have you had animal allergy symptoms within the past 12 months?**

|  |  |
| --- | --- |
| Yes | No |
|  |  |

*If yes,* please list the animal(s) and your associated allergy symptoms:

|  |
| --- |
|  |

 *If yes,* what is the severity of your animal allergy symptoms and what allergy treatment are you currently using?

|  |
| --- |
|  |

**3.** **Are you allergic to any environmental allergens (grass, pollen, etc)?**

|  |  |
| --- | --- |
| Yes | No |
|  |  |

*If yes,* please list environmental allergens and your associated allergy symptoms:

|  |
| --- |
|  |

**4. Have you had these environmental allergy symptoms in the past 12 months?**

|  |  |
| --- | --- |
| Yes | No |
|  |  |

 *If yes,* what is the severity of your environmental allergy symptoms and what environmental allergy treatment are you currently using?

|  |
| --- |
|  |

**5. Do you have asthma?**

|  |  |
| --- | --- |
| Yes | No |
|  |  |

 *If yes,* please describe your asthma triggers (if known):

|  |
| --- |
|  |

**6.** **Have you had asthma symptoms within the past 12 months?**

|  |  |
| --- | --- |
| Yes | No |
|  |  |

 *If yes,* what is the severity of your symptoms and what asthma treatment are you currently using?

|  |
| --- |
|  |

**7. Do you have allergy or asthma symptoms related to your work?**

|  |  |
| --- | --- |
| Yes | No |
|  |  |

 *If yes,* please describe / provide examples of your allergy or asthma symptoms at work

|  |
| --- |
|  |

**8. Have you had these symptoms within the past 12 months?**

|  |  |
| --- | --- |
| Yes | No |
|  |  |

 *If yes,* what is the current severity of these symptoms and what treatment are you currently using for your work-related allergy or asthma symptoms?

|  |
| --- |
|  |

**9. Have you had skin problems caused or exacerbated by your work activities?**

|  |  |
| --- | --- |
| Yes | No |
|  |  |

 *If yes,* please describe the skin problem and what treatment you are currently using for the problem.

|  |
| --- |
|  |

**C. CONDITIONS WITH INCREASED RISKS**

**1. PREGNANCY**: **Are you pregnant or planning to become pregnant in the next year?**

|  |  |
| --- | --- |
| Yes | No |
|  |  |

**2.**  **RISK FROM LOWERED IMMUNITY**: **Are you immunocompromised due to certain diseases (such as cancer, lupus, rheumatoid arthritis, HIV) or due to medical treatment?** (e.g. receiving steroids, radiation therapy, chemotherapy)?

|  |  |
| --- | --- |
| Yes | No |
|  |  |

**D. INJURY/ILLNESS DURING PAST 12 MONTHS *Please check any of the following problems you have had in the past 12 months:***

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Chronic cough |  | Other muscle/joint injury |  | Animal bite/scratch |
|  | Abdominal cramping |  | Fatigue |  | Needle/puncture wound |
|  | Diarrhea |  | Weight loss |  | Chemical exposure |
|  | Hand/wrist pain |  | Fever |  | Other: |
|  | Back pain/injury |  | Infection |

**E. WORK-RELATED HEALTH CONCERNS**

***Do you have any work-related health concerns that you would like to confidentially discuss and/or further evaluate with an occupational health care professional***?

|  |  |
| --- | --- |
| Yes | No |
|  |  |

***To the best of my knowledge, the information included herein is true:***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Individual Completing This Form Date**

*After you complete this form, schedule an appointment with the Health and Wellness Center for a “Physical” appointment. You will meet with a health professional from Health and Wellness Center at Lake Forest College to be evaluated for clearance. By signing this form, you provide consent for the Health and Wellness Center to contact IACUC with your name and your clearance status (i.e., medical evaluation is complete).*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Health Professional Evaluating Form Date**